MY CSHCS PLAN OF CARE – PART A

DATE PLAN DEVELOPED:

NAME:	PLAN OF CARE COMPLETED ☐ FACE TO FACE ☐ IN HOME ☐ OVER PHONE
AKA:	ETHNICITY ☐ African American ☐ American Indian ☐ Asian ☐ Hispanic ☐ White Non-Hispanic ☐ Other
M ☐ F ☐ DOB:	
ADDRESS:	CITY: ZIP:
TEL #	CSHCS ELIG DATES:
ALTERNATIVE TEL #	CO CODE: CO NAME:
RECIPIENT ID#:	
CHILD LIVES WITH ☐ Biological Family ☐ Extended Family ☐ Adoptive Family ☐ Foster Family ☐ Blended Family ☐ Other Explain	
PARENTS/GURADIANS:	
Comments:	
PRIMARY CARE GIVER:	
PRIMARY CARE GIVER SPEAKS: IS: ☐NON-VERBAL ☐ DEAF ☐ BLIND	TRANSLATOR NAME/CONTACT INFO:
EMERGENCY CONTACT/BACK UP CAREGIVER:	PHONE: RELATIONSHIP:
EMERGENCY PLAN IN PLACE☐ YES ☐ NO	TURNING 21 IN 12 MONTHS OR LESS ☐ YES ☐ NO
Would you like assistance to put one together? ☐ YES☐ NO	Would you like assistance with the transition? ☐ YES ☐ NO

CARE COORDINATOR:	TEL #:

MY INSURANCE INFORMATION

INSURANCE NAME:	Insurance Type Med ☐ Rx ☐ Dental ☐ Vision ☐	ID#	TEL#
POLICY HOLDER:	Primary ☐ Secondary ☐	CASEWORKER:	TEL#

INSURANCE NAME:	Insurance Type Med ☐ Rx ☐ Dental ☐ Vision ☐	ID#	TEL#
POLICY HOLDER:	Primary ☐ Secondary ☐	CASEWORKER	TEL#

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POLICY HOLDER:	Primary ☐ Secondary ☐	CASEWORKER	TEL#

MY QUALIFYING DIAGNOSES & PHYSICIAN INFORMATION
NOTE: Includes all physician providers regardless of specialty.

Medical Home/Primary Care Doctor Name	Last:	First:
Address:	Clinic Name:	
	Doctor Type:	
Phone:	Office Hours:	
Fax:	After Hours Number:	
Date of last well exam:	Immunizations: ☐ Up to date ☐ Needed	
Lead Testing: ☐ Completed ☐ Needed	Record Attached: ☐ Yes ☐ No	
Comments:		

CSHCS Qualifying Diagnoses

	Primary Code	Narrative		Secondary Code	Narrative
1			**2**		
3			**4**		
5			**6**		
7			**8**		

Specialty Physician Providers

CSHCS Covered? ☐ YES ☐ NO

Specialty Physician Name	Last:	First:
Address:	Clinic Name:	
	Specialty:	
Phone:	Office Hours:	
Fax:	After Hours Number:	
Comments:		

CSHCS Covered? ☐ YES ☐ NO

Specialty Physician Name	Last:	First:
Address:	Clinic Name:	
	Specialty:	
Phone:	Office Hours:	
Fax:	After Hours Number:	
Comments:		

CSHCS Covered? ☐ YES ☐ NO

Specialty Physician Name	Last:	First:
Address:	Clinic Name:	
	Specialty:	
Phone:	Office Hours:	
Fax:	After Hours Number:	
Comments:		

Member Name____ID____________________

	CSHCS Covered?	☐YES	☐NO

Specialty Physician Name	Last:	First:

Address:	Clinic Name:
	Specialty:
Phone:	Office Hours:
Fax:	After Hours Number:
Comments:	

	CSHCS Covered?	☐YES	☐NO

Specialty Physician Name	Last:	First:

Address:	Clinic Name:
	Specialty:
Phone:	Office Hours:
Fax:	After Hours Number:
Comments:	

	CSHCS Covered?	☐YES	☐NO

Specialty Physician Name	Last:	First:

Address:	Clinic Name:
	Specialty:
Phone:	Office Hours:
Fax:	After Hours Number:
Comments:	

Other Providers – Hearing, Vision, Nursing, Mental Health, etc.

Provider Name		CSHCS Covered? ☐ Yes ☐ No

Address:	Contact Person:
	Service Provided:
Phone:	Comments:
Fax:	Comments:

Provider Name		CSHCS Covered? ☐ Yes ☐ No

Address:	Contact Person:
	Service Provided:
Phone:	Comments:
Fax:	Comments:

Member Name____ID____________________

Provider Name		CSHCS Covered? ☐ Yes ☐ No
Address:	Contact Person:	
	Service Provided:	
Phone:	Comments:	
Fax:	Comments:	

Provider Name		CSHCS Covered? ☐ Yes ☐ No
Address:	Contact Person:	
	Service Provided:	
Phone:	Comments:	
Fax:	Comments:	

Rehabilitation Providers

Provider Name		CSHCS Covered? ☐ Yes ☐ No
Address:	Contact Person:	
	Service Provided:	
Phone:	Visits per week:	
Fax:	After Hours Number:	
Comments:		

Provider Name		CSHCS Covered? ☐ Yes ☐No
Address:	Contact Person:	
	Service Provided:	
Phone:	Visits per week:	
Fax:	After Hours Number:	
Comments:		

Provider Name		CSHCS Covered? ☐ Yes ☐No
Address:	Contact Person:	
	Service Provided:	
Phone:	Visits per week:	
Fax:	After Hours Number:	
Comments:		

Hospital Providers

Hospital Name		CSHCS Covered? ☐ Yes ☐ No
Address:	Urgent Care Phone Number:	
	Emergency Room Number:	
Phone:	Date of Last Visit:	Reason? ☐In Pt ☐ER ☐ UC

Member Name_____ID_____

Hospital Name		CSHCS Covered? ☐ Yes ☐ No
Address:	Urgent Care Phone Number:	
	Emergency Room Number:	
Phone:	Date of Last Visit:	Reason? ☐In Pt ☐ER ☐ UC

PHARMACY PROVIDERS

Pharmacy Name:		Pharmacy Name:	
Address:		Address:	
Phone:	Fax:	Phone:	Fax:
Hours:		Hours:	

DURABLE MEDICAL EQUIPMENT/MEDICAL SUPPLIES

Provider Name		Provider Name:	
Address:		Address:	
Phone:	Fax:	Phone:	Fax:
Hours:		Hours:	
Type of Services:		Type of Service:	

Provider Name		Provider Name:	
Address:		Address:	
Phone:	Fax:	Phone:	Fax:
Hours:		Hours:	
Type of Services:		Type of Service:	

TRANSPORTATION

Name:	Name:
Phone:	Phone:
Special Instructions:	Special Instructions:

MY DAY CARE/SCHOOL/EMPLOYMENT INFORMATION

DAY CARE/SCHOOL NAME:		CONTACT NAME:
Address:		Schedule:
Phone:	Fax:	How transported:
Grade/Placement:		Type of class:

Member Name_____ID_____

Current Educational Challenges:	Date of last IEP:
School Based Services:	Contact Name:
School Based Services:	Contact Name:
EMPLOYER NAME:	CONTACT NAME:
Hours worked per week:	Phone:

BRIEF, CONCISE PAST MEDICAL HISTORY

Surgeries (type, date, reason, outcome)	
Hospitalizations (date, reason, name of facility)	
E.R. visits (date, reason, where) last 12 mos. only	
Other	

RELEVANT PSYCHOSOCIAL HISTORY AND CURRENT PSYCHOSOCIAL STATUS OF THE CHILD

Identify situations such as: family recently moved; recent parental illness, medical needs or history pertinent to child's psychosocial status; parental absence; child experienced serious danger/trauma; sibling(s) with complex medical concerns; positive experiences such as hobbies, leisure activities, club involvement, family strengths, priorities and stresses, etc
History:
Current Status:

MY CURRENT MEASURMENTS

Height:	Weight:
Percentage for age: %	Percentage for age: %
Height is: ☐ under ☐ normal ☐ over	Weight is: ☐ under ☐ normal ☐ over

MY DEVELOPMENT *Indicate child's developmental level*

Gross Motor Skills:	Fine Motor Skills:
Cognitive level:	
Communication/Language: ☐ Within Normal Limits ☐ Computer ☐ Sign Language ☐ Communication Board ☐ Lip-reads ☐ Interpreter ☐ Communication Book ☐ Does Not Communicate ☐ Other	
Social Interactions:	Adaptability:

MY MEDICATIONS – *List all prescription and non-prescription medications and frequency*

Name of Drug	Frequency/Route	Reason		Name of Drug	Frequency/Route	Reason

REVIEW OF SYSTEMS: *Specify child's current condition/status in each (coordinate with Brief Past Medical History)*

Allergies	Medications: Foods: Environmental:
Neurological	
Cardiovascular	
Respiratory	
Musculoskeletal	
Gastrointestinal	
Genitourinary	
Hematological	
Endocrine	
Skin	
Vision	
Hearing	
Dental	
Nutrition	Is your child under the care of a health care professional for diet/nutrition? ☐ NO ☐ YES Current Diet: Diet taken by ☐ Mouth ☐ Tube
Other	

MY DURABLE MEDICAL EQUIPMENT/MEDICAL SUPPLIES *Identify all DME used by the child. Note if the equipment is used at home or school, owned, borrowed or rented. Includes respiratory, mobility, positioning aids, O&P, monitoring devices, external infusion pumps, and rehab equipment such as wheelchair, stroller, walker, stander, orthotics, prosthetics, lift, bath equipment, positioning devices, custom chair, hospital bed, car seat, toileting system, ventilator, generator, suction machine, oxygen concentrator, oxygen humifier, oxygen monitor, pulse ox, apnea monitor, nebulizer, communication board, glucometer, insulin pump, etc.*

Name of Equip	**Type**	**Own**	**Rent**	**Borrow**	**School**	**Home**	**Comments/Age/Condition**
Ex: BP Monitor	*Manual*	*X*			*X*	*X*	*2 yrs old is growing out of cuff size*

Member Name_____ID_____

A DAY IN THE LIFE OF THE CHILD *Describe personal care capabilities/needs using the following key..*

- *I = child is able to do by him/herself, Independent*
- *NH = child needs help, but within normal limits for age*
- *SI = child needs more help or needs more time than most children his/her age, Semi-Independent*
- *TD = totally dependent on others for this task*

Feeding: I☐ NH☐ SI☐ TD☐ **Dressing**: I☐ NH☐ SI☐ TD☐ **Bathing**: I☐ NH☐ SI☐ TD☐

Play I☐ NH☐ SI☐ TD☐ **Toileting** I☐ NH☐ SI☐ TD☐ **Mobility** I☐ NH☐ SI☐ TD☐

Approximate time to get ready for physician visits? for school?

Sleep Habits

THE FAMILY SUPPORT SYSTEM

Who lives in the home with the child?
What is the family employment situation? Location? Work hours? Flexibility? Limitations?
Does the family have access to transportation? Explain
Does the family have any housing concerns? Explain
Religious Preference? Active in religious community?
Is guardianship in place if necessary? Who is named as guardian?

FOR FOSTER CARE CHILDREN

How long has the child been in this foster home?
What is the goal of current foster care case plan?
Is the biological family involved in the care of the child? Will they be?
Supervisory agency name and phone:

COMMUNITY SERVICES AND RESOURCES

☐ Community Mental Health; CMH: Contact: _____ Phone: _____
☐ Early On Contact: _____ Phone:_____
☐ Family & Neighborhood Services Contact: _____ Phone: _____
☐ Family Independency Agency Contact: _____ Phone: _____
☐ Food Stamps Contact: _____ Phone: _____
☐ Head Start Contact: _____ Phone: _____
☐ Infant Support Services; ISS: Contact: _____ Phone:_____
☐ SSI Contact: _____ Phone: _____
☐ Waiver Contact: _____ Phone: _____
☐ WIC Contact: _____ Phone: _____
☐ Other Contact: _____ Phone: _____

Member Name_____ID_____

☐ Other Contact: _____Phone: _____

MEMBER/GUARDIAN

I have actively participated in the development of this Plan of Care. I understand and agree with this plan.
I understand that this is a plan developed to assist in the coordination of care for myself/child. Authorization and payment for services, described in this plan of care are not the responsibility of Kids Connection.

I authorize my health care and school providers to release the most current medical, and educational information from the past twelve (12) months, which may include medical reports, letters from physician specialists, office or hospital inpatient or outpatient summaries that relate to the status of medical problems, ongoing treatment plans, progress reports, and IEP information to Kids Connection, located at 2500 Green Road, Suite 700 Ann Arbor, MI 48105.

These records may include information about Human Immune Deficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), and AIDS Related Complex (ARC).

A copy of this signed form is considered valid for the purposes of care coordination/case management.
This authorization expires in 12 months from the date signed.

Parent / Legal Guardian_____Date Signed_____

Care Coordinator _____Date Signed _____

Completed Copies Sent to ☐ Parents ☐ Primary Care Doctor ☐ LHD Date_____Int.____

CSHCS PLAN OF CARE – PART B

DATE OPENED	OPPORTUNITY / CONCERN	GOAL OF INTERVENTION	INTERVENTION	OUTCOME OF COMPLETED INTERVENTION	BARRIERS	DATE CLOSED

Member Name_____ID_____